

# **CLARK COUNTY**

## **REQUEST FOR PROPOSALS**



### **# 485**

### **Program for Assertive Community Treatment (PACT)**

**ISSUING AGENCY:**  
**Clark County Office of Purchasing**

**ISSUED ON BEHALF OF:**  
**The Department of Community Services**

**RELEASED: January 10, 2007**

**CLOSES: February 16, 2007**

**PROPOSALS MUST BE SUBMITTED NO LATER**

**THAN 4:30 P.M. TO:**

**Clark County  
Office of Purchasing  
P.O. Box 5000  
1300 Franklin Street, 6<sup>th</sup> Floor, Suite 650  
Vancouver, Washington 98660  
(360) 397-2323**

**FOR ALTERNATIVE FORMATS**



**Clark County ADA Office; V (360) 397-2025;  
TTY (360) 397-2445; ADA@Clark.wa.gov**

# Request for Proposals

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## **Request for Proposal # 485**

### **Program for Assertive Community Treatment**

#### **1.0 Introduction, Background, and General Information**

##### **1.1 Purpose**

The State Mental Health Division is providing funding to Clark County through its Department of Community Services, which functions as a Regional Support Network, to develop and implement an additional Program for Assertive Community Treatment (PACT) Team. One goal is to enable regional support networks (RSNs) to achieve significant reductions in the number of beds needed at the state hospitals.

##### **1.2 Program Description and Objectives**

###### State Program Objectives

The 2006 Washington State Legislature allocated fiscal year 2007 funds to the State Department of Social and Health Services (DSHS) Mental Health Division (MHD) for the development and initial implementation of Program for Assertive Community Treatment (PACT) Teams and other proven program approaches to enable regional support networks (RSNs) to achieve significant reductions in the number of beds needed at the state hospitals. It is expected that the legislature will fully fund the implementation of PACT programs in the 2007 legislative session for the 2007-2009 biennium.

The PACT Teams will have to maintain 90% compliance with the PACT Fidelity scale, Attachment D. The PACT Model the state is supporting is the Dartmouth Assertive Community Treatment Fidelity Scale (Attachment D). The *Washington State PACT Program Standards Draft 10/04/06* (Attachment B) is based upon the *National Program Standards for ACT Teams*, Deborah Allness, M.S.S.W. and William Knoedler, M.D. 2003.

There will be funding support from the State MHD to Regional Support Networks (RSNs) for 6 full PACT teams and 4 partial PACT teams. One partial PACT team based on a rural model has been allocated to Clark County (rural means the capacity to serve 42 – 50 participants).

The state-wide values/goals for the PACT Teams are:

1. Services are consumer driven, they support recovery, and are not coercive;
2. Participants and family members are involved in planning, both at the state and local levels;

3. PACT services are individually tailored with each consumer and address the preferences and identified goals of each participant;
4. Independent housing and employment for participants are priorities; and
5. Services must result in sustained overall reduction in state hospital utilization by the RSNs with PACT teams.

DSHS expects that the successful implementation of PACT teams will create an alternative resource that will allow for the planned reduction of up to 160 beds statewide at the state hospitals.

#### Local Program Objectives

In Clark County, PACT funds will be utilized to serve adults with serious and persistent mental illness. The PACT program is consistent with the Clark County Department of Community Services priorities of reducing the number of county residents who are hospitalized at Western State Hospital, are at risk of being hospitalized, and serving people with persistent mental illness in their community.

The overarching goal of the PACT program is to provide eligible persons with housing and coordinated support services to enable them to live in the community in the least restrictive environment, with minimal dependence on and use of public safety and acute care resources.

### 1.3 Project Design Requirements

#### PACT Project Design

PACT is a consumer-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

PACT utilizes a multi-disciplinary team treatment approach that operates 24 hours, 7 days a week to provide the majority of the treatment, rehabilitation, and support services consumers need to achieve their goals. PACT is one of six evidence-based practices identified by the Substance Abuse and Mental Health Services Administration (SAMHSA). PACT was initially developed in the 1970's as a "hospital without walls" based on the work of Arnold Marx, M.D., Leonard Stein and Mary Ann Test, Ph.D. The model has since been widely implemented in the United States and Canada. Extensive research and evaluation has proven the clinical and cost effectiveness of PACT.

The PACT is a service-delivery model that fosters integration, teamwork and continuity of care. The model includes:

1. Multi-disciplinary staffing
2. Team approach
3. Integration of all services
4. Low participant-staff ratios
5. Locus of contact in the community
6. Assertive outreach and engagement
7. Focus on symptom management and everyday problems of living
8. Ready access in times of crisis

PACT Team members include the following staff disciplines: psychiatrist or psychiatric nurse practitioner, registered nurse, mental health professional, chemical dependency specialist, vocational specialist, and peer counselor. The PACT Team shall have the organizational capacity to provide a minimum staff-to-consumer ratio of at least one full-time equivalent (FTE) staff person for every 8 consumers (not including the psychiatric prescriber and the program assistant).

#### Local Program Requirements

It is the intent of this Request For Proposal (RFP) to solicit a Provider to implement one partial PACT team that will serve 42 - 50 consumers throughout Clark County who are:

1. Currently hospitalized at Western State Hospital (WSH) or are at risk of being hospitalized, or are hospitalized at community psychiatric hospitals in Clark County; or
2. Incarcerated in Clark County; or
3. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available; or
4. Having significant difficulty maintaining a safe living situation and/or meeting basic survival needs or residing in substandard housing, homeless or at imminent risk of becoming homeless.

The PACT Teams will serve consumers residing in Clark County with a primary goal of significantly reducing the census of CCRSN consumers hospitalized in WSH and community psychiatric hospitals. Since the PACT model is a service provided in the community, where a potential consumer lives and works, proposals should demonstrate how services might meet the needs of persons from different parts of the region.

PACT is not a Medicaid funded service and will be paid by state mental health funds. Medicaid eligibility is not a requirement for participating in this program. Participants in this program will receive all public mental health services in this program and will not receive Medicaid funded services.

This RFP is the CCRSN's anticipated framework for how the PACT Teams will be structured and implemented in Clark County. Based on decisions that still need to be finalized at the state and local level, there may be modifications to the PACT program in any resulting contract.

#### 1.4 Authorized receipt of RFP

All proposers shall be listed on the Plan Holders List to be considered responsive.

Contact Clark County Purchasing via e-mail at: [linnea.larocque@clark.wa.gov](mailto:linnea.larocque@clark.wa.gov) or call (360) 397-2323, to be included on the Plan Holders list and request a copy (via email or standard mail) of this document. Include, with your request, the following information: RFP number and title; Your Agency's name; address; and phone number.

#### 1.5 Funds Available and Source of Funding

All funds will be state mental health funds. Up to \$142,500 will be available to cover costs in the start up period of April 1, 2007 through June 30, 2007. It is anticipated that up to \$596,000 will be available for funding the program for the next fiscal year. Funding during the first year of the program will be on a cost reimbursement basis.

#### 1.6 Proposer's Conference

A Proposers Conference will be held on January 18, 2007 at 3:00 p.m. in Building 14, Room 210C located at the Center for Community Health, 1601 E. Fourth Plain, Vancouver, WA

#### 1.7 Duration of Contract

A contract awarded as a result of this RFP is intended to start March 1, 2007 and end June 30, 2008. The contract may be renewed for an additional two year period upon satisfactory performance.

#### 1.8 Type of Contract

The Contract will be a cost reimbursement agreement for the first year of operation.

## 1.9 Prospective Contractor's Administration

Any organization operating a program funded by Clark County shall have demonstrated administrative and accounting capabilities necessary to safeguard all public funds.

## 1.10 Questions and Answers

Questions should be directed to Clark County Purchasing via e-mail at:  
[linnea.larocque@clark.wa.gov](mailto:linnea.larocque@clark.wa.gov)

To review questions and answers regarding this rfp please visit our web site:  
<http://www.clark.wa.gov/general-services/purchasing/rfp.html>

## 2.0 General Requirements

### 2.1 Independent Price Determination

The prospective contractor guarantees that, in connection with this proposal, the prices and/or cost data have been arrived at independently, without consultation, communication, or agreement for the purpose of restricting competition. This does not preclude or impede the formation of a consortium of companies and/or agencies for purposes of engaging in jointly sponsored proposals.

### 2.2 Authorship

Applicants must identify any assistance provided by agencies or individuals outside the proposer's own organization in preparing the proposal. No contingent fees for such assistance will be allowed to be paid under any contract resulting from this RFP.

All proposals submitted become the property of Clark County. It is understood and agreed that the prospective contractor claims no proprietary rights to the ideas and written materials contained in or attached to the proposal submitted.

### 2.3 Price Warrant

The proposal shall warrant that the costs quoted for services in response to the RFP are not in excess of those which would be charged any other individual or entity for the same services performed by the prospective contractor.

## 2.4 Conflict of Interest

All proposals submitted must contain a statement disclosing or denying any interest, financial or otherwise, that any employee or official of Clark County or the appropriate Advisory Board may have in the proposing agency or proposed project.

## 2.5 Subcontracting

No activities or services included as a part of this proposal may be subcontracted to another organization, firm, or individual without the approval of Clark County. Such intent to subcontract shall be clearly identified in the proposal. All subcontracts will require prior review and approval of Clark County. It is understood that the contractor is held responsible for the satisfactory accomplishment of the service or activities included in a subcontract.

## 2.6 Consortium of Agencies

Any consortium of companies or agencies submitting a proposal must certify that each company or agency of the consortium can meet the requirements set forth in the RFP.

## 2.7 Equal Opportunity

It is the policy of Clark County to require equal opportunity in employment and services subject to eligibility standards that may be required for a specific program.

No person shall, on the grounds of race, color, religion, sex, handicap, national origin, age, citizenship, marital status, political affiliation or belief, be denied employment or benefits, or be discriminated against as a consumer, administrator or staff person under any program or activity receiving funds under this RFP.

In compliance with Department of Labor Regulations implementing Section 504 of the Rehabilitation Act of 1973, as amended, no qualified handicapped individual shall be discriminated against in admission or access to any program or activity.

The prospective contractor must agree to provide equal opportunity in the administration of the contract, and its subcontracts or other agreements.

## 2.8 Award of Contract

The contract award will not be final until Clark County and the prospective contractor have executed a contractual agreement. The contractual agreement consists of the following parts: (a) the basic provisions and general terms and conditions, (b) the

special terms and conditions, (c) the project description and goals (Statement of Work), and (d) the budget and payment terms. Clark County is not responsible for any costs incurred prior to the effective date of the contract. Clark County reserves the right to make an award without further negotiation of the proposal submitted. Therefore, the proposal should be submitted in final form from a budgetary, technical, and programmatic standpoint.

## 2.9 Debarment and Suspension

The contractor must certify that they are not debarred or suspended or otherwise excluded from or are ineligible for participation in Federal Assistance programs under Executive Order 12549, "Debarment and Suspension". The contractor must also certify that it will not contract with a subcontractor that is debarred or suspended.

## 2.10 Limitation

This RFP does not commit Clark County to award a contract, to pay any costs incurred in the preparation of a response to this RFP, or to procure or contract for services or supplies. Clark County reserves the right to accept or reject any or all proposals received as a result of this RFP, to negotiate with all qualified sources, to waive formalities, to postpone award, or to cancel in part or in its entirety this RFP if it is in the best interest of Clark County to do so.

## 2.11 Cancellation of Award

Clark County reserves the right to immediately cancel an award if the contractual agreement has not been entered into by both parties or if new state regulations or policy make it necessary to change the program purpose or content, discontinue such programs, or impose funding reductions. In those cases where negotiation of contract activities are necessary, Clark County reserves the right to limit the period of negotiation to sixty (60) days after which time funds may be unencumbered.

## 2.12 Interlocal Agreements

Clark County has made this RFP subject to Washington State statute RCW 39.34. Therefore the proposer may, at the proposer's option, extend identical prices and services to other public agencies wishing to participate in this RFP. Each public agency wishing to utilize this RFP will issue a purchase order (or contract) binding only their agency. Each contract is between the proposer and the individual agency with no liability to Clark County.

## 2.13 Environmentally Responsible Purchasing Program

Clark County has implemented an Environmentally Responsible Purchasing Policy with a goal to reduce negative impacts on human health and the environment. Negative environmental impacts include, but are not limited to, greenhouse gases, air pollution emissions, water contamination, waste from the manufacturing process and waste in packaging.

This policy also seeks to increase:

- 1) water and energy efficiency
- 2) renewable energy sources
- 3) use of products with recycled content
- 4) product durability
- 5) use of products that can be recycled, reused, or composted at the end of its life cycle.

Product criteria have been established on the Green Purchasing List <http://www.clark.wa.gov/general-services/purchasing/erp/environmental.html>

## 3.0 Administrative Requirements

Contractors shall comply with all management and administrative requirements established by Washington Administrative Code (WAC), the Revised Code of the State of Washington (RCW), and any subsequent amendments or modifications, as applicable to providers licensed in the State of Washington.

### 3.1 Single Audit Requirements

If required, audits shall be performed in accordance with OMB Circular A-133 and shall be received by Clark County within the 9 month period following the close of each fiscal year. All audit costs shall be the contractor's responsibility. Agencies not covered by federal single audit requirements may be responsible for an independent agency audit which meets general accepted auditing standards.

### 3.2 Other Audit/Monitoring Requirements

In addition, auditing or monitoring for the following purposes will be conducted at the discretion of Clark County:

- a. Fund accountability;
- b. Contract compliance; and
- c. Program performance.

### 3.3 Insurance

Prior to the signing of a contract, the contractor(s) selected must show evidence of a certificate of commercial liability for a minimum of \$2,000,000 and a professional errors and omissions insurance policy with a minimum of \$3,000,000 per occurrence identifying Clark County, its elected officials, officers, employees and its agents as an additional insured.

All policies must have a Best's Rating of A-VII or better.

## 4.0 **Proposal Development**

### 4.1 Proposal Format

Directions for developing a proposal are included in Attachment A. Acceptance of proposals is based, among other criteria, on detailed adherence to the directions outlined in Attachment A. Clark County reserves the right to reject proposals not in compliance with this requirement.

### 4.2 Proposal Content

At the time of submission, the proposal must provide a full description of all services following the outline presented in Attachment A. The proposal must enable readers to understand how the agency intends to use these public funds and what measurable outcomes are expected to be achieved. (See instructions in Attachment A for more information.)

Proposers are reminded that proposals will be considered exactly as submitted. Points of clarification will be solicited from proposers at the discretion of Clark County. Those proposals determined to not be in compliance with provisions of this RFP and the applicable law and/or regulations will not be processed.

The information and proposed budget for the agency selected for contract award will form the basis for negotiation of a contract. Clark County reserves the right to issue a contract without further negotiation using the data contained in the RFP. Failure of a prospective contractor to accept this method of contract development will result in cancellation of the award.

## 5.0 **Proposal Submission**

### 5.1 Schedule

The original proposal package (with the appropriate number of copies) must be delivered to the following location no later than 4:30 p.m. on February 16, 2007:

Clark County Purchasing Department  
1300 Franklin Street – 6<sup>th</sup> floor, Suite 650  
Vancouver, Washington 98660

Original documents and appropriate copies must be delivered to the Clark County Purchasing Department in sealed package (s). Include RFP# and Name/Organization visibly located on outside of package.

Proposals received with insufficient copies cannot be properly disseminated to the Review Committee and other reviewers for necessary action and therefore may not be processed.

COPIES REQUIRED: One (1) Original and four (4) Copies

5.2 Late Proposals

A proposal received after the date and time indicated above will not be accepted. No exceptions will be made.

5.3 Verbal Proposals

Verbal proposals will not be considered in making the award of any contract as a result of this RFP.

5.4 Oral Presentations

An oral presentation may be required of those prospective contractors whose proposals are under consideration. Prospective contractors may be informed that an oral presentation is desired and will be notified of the date, time and location the oral presentation is to be conducted.

5.5 Rejection of Proposals

Clark County reserves the right to reject any or all proposals received and to negotiate with any or all prospective contractors on modifications to proposals.

5.6 Letter of Intent

Agencies intending to submit a proposal must submit a letter of intent to:

Clark County Purchasing Department  
1300 Franklin Street – 6<sup>th</sup> floor, Suite 650  
Vancouver, Washington 98660

No later than 4:30 pm on January 19, 2007. This letter should identify the agency, reference this RFP and be signed by an individual in the organization authorized to sign contracts. This letter does not obligate the organization to submit a proposal.

Agencies that do not submit a letter of intent will not have their proposals considered.

## **6.0 Proposal Evaluation and Selection**

### **6.1 Evaluation and Selection Process**

Proposals received in response to this RFP will be evaluated by a Review Committee. Committee review results and recommendations may be presented to an appropriate advisory board prior to final selection.

### **6.2 Evaluation and Selection Criteria**

Each proposal received in response to the RFP will be objectively evaluated and rated using the evaluation criteria listed below. The top finalist(s) may be asked to give a presentation to the selection committee.

The proposal will be evaluated to determine if it complies with the requirements contained within the RFP. If it does not, the County may disqualify the proposal from further consideration.

Scoring (See Part III for Requirements and Criteria)

1.	Experience of Service Provision	20
2.	Services to be Provided	40
3.	Housing	5
4.	Evidence Based/Promising Practices to be provided	5
5.	Collaboration	5
6.	Budget Detail and Narrative	15
7.	Provider Performance on current and past projects and contracts	10
	Total Proposal Scoring	100
	Optional Interview	5

### 6.3 Disputes

Clark County encourages the use of informal resolution to address complaints or disputes arising over any actions in implementing the provisions of this RFP. Written complaints should be addressed to Clark County – Purchasing, P.O. Box 5000, Vancouver, Washington 98666-5000.

## **Attachment A**

### Directions for Developing a Proposal

These instructions were developed to aid in proposal development. They also provide for a structured format so reviewers can systematically evaluate several proposals. These directions apply to all proposals submitted.

An original and each copy of the proposal package must include all of the sections in the order indicated; attachments should be clearly referenced and identified to facilitate the review process.

Part I: The "Proposal Summary" form is designed to serve as the cover sheet. Do not attach cover letters, title pages, or blank sheets ahead of this form, nor substitute letterhead paper for it. If additional space is needed plain paper may be attached behind this form. Special bindings are not required for submittal of your proposal. This form must be signed by a person authorized to make proposals and enter into contract negotiations on behalf of your agency.

Part II: The Statement Of Contractor Qualifications should be completely filled out. This provides needed information on your agency's administrative, organizational, fiscal, and base program qualifications to be awarded a contract for these services with Clark County. These qualifications must be maintained during the entire course of any grant or contract. Misrepresentation of the information submitted in response to this section may result in the immediate termination of further business relationships with the proposer.

Part III: Program Questions/Description – please see Attachment B “Statement of Work”, for a description of the program. The contractor should develop their response as a separate document and label the document “Part III: Program Questions/Description”, including the RFP Title.

Part IV: The "Budget Summary" section includes your agency's line item budget for this service. A computer spreadsheet which addresses the minimum line item elements is desired. Please label the document Part IV: Budget Summary.

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**Program for Assertive Community Treatment**

Part I PROPOSAL SUMMARY

General Information:

Legal Name of Applicant Agency\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Program Location (if different than above) \_\_\_\_\_

Email address \_\_\_\_\_

Tax Identification Number \_\_\_\_\_

Total Funds Requested Under this Proposal \$ \_\_\_\_\_

Did outside individuals or agencies assist with preparation of this proposal?

\_\_\_\_\_Yes \_\_\_\_\_No If yes, describe.

I certify that to the best of my knowledge the information contained in this proposal is accurate and complete and that I have the legal authority to commit this agency to a contractual agreement. I realize the final funding for any service is based upon funding levels, and the approval of the Clark County Board of Commissioners.

\_\_\_\_\_  
Signature, Administrator of Applicant Agency

\_\_\_\_\_  
Date

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**Program for Assertive Community Treatment**

Part II. STATEMENT OF AGENCY QUALIFICATIONS

Note: If additional space is needed, please attach additional sheet(s).

Legal Name of Applicant Agency \_\_\_\_\_

Contact Person \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Minimum Qualifications: Proposals from agencies not meeting these minimum qualifications will not be reviewed.

1. Does your agency currently have or will be able to obtain a Washington State Community Mental Health Center license prior to the start of the contract in March 2007?

☐ Yes (please attach documentation)

☐ No

2. Is your agency able to provide services in compliance with PL 101-645 Title V, Subtitle B; Part 438 Balanced Budget Act (BBA); 45 CFR Health Insurance Portability and Accountability Act (HIPAA), Parts 160 and 164; the Revised Code of Washington (RCW) 71.05, 71.24; Washington Administrative Code (WAC) 388-865; the CCRSN Policies and Procedures and its revisions; and the Regional Support Network/Western State Hospital Working Agreement and its successors?

☐ Yes, if yes, what evidence do you have of ability to meet these requirements?

☐ No

3. Is your agency able to submit data electronically in the MHD approved format to the CCRSN Information System.

☐ Yes, if yes, describe your ability to meet these requirements?

☐ No

A. Type of Organization

\_\_\_ Private for profit      \_\_\_ Unit of local or state  
\_\_\_ Public non-profit  
\_\_\_ Other (specify)  
\_\_\_ Private non-profit

B. Registration Requirement

Each prospective contractor must provide the following:

1. Washington State Tax Registration Number \_\_\_\_\_
2. Employer Identification Number \_\_\_\_\_
3. Other Appropriate Licenses \_\_\_\_\_
4. State License Number \_\_\_\_\_

- C. Does your agency have an Governing Board? If yes, attach a list of all members and representation.

- D. Was the proposal developed under the guidance of an advisory board or committee?  
\_\_\_\_\_ Yes      \_\_\_ No  
(If yes, please identify, indicate how developed, including credentials of the developer.)

E. Agency Information

The following have been approved and adopted by the agency's Board of Directors:

Written Personnel/EEO Policies	[ ] Yes	[ ] No	[ ] N/A
Staff Job Descriptions	[ ] Yes	[ ] No	[ ] N/A
Written Benefits Policies	[ ] Yes	[ ] No	[ ] N/A
Affirmative Action Plan	[ ] Yes	[ ] No	[ ] N/A

F. Litigation Status

Is your agency currently involved in or does it have pending any legal actions? Has your agency filed for bankruptcy in the past five years?

\_\_\_\_ Yes \_\_\_\_ No (If yes, please explain.)

G. Briefly describe your agency's accounting process for tracking expenditures/revenues to separate accounts.

H. Briefly describe your funding base/revenue sources for the past two (2) years. Provide at least one financial reference, preferably a bank, which can attest to your agency's financial well being and financial management capabilities.

I. Describe your agency's ability to repay any disallowed costs.

J. Does your organization conduct an internal audit of funds under its control?

\_\_\_\_ Yes \_\_\_\_ No If yes, how often is such an internal audit conducted?

K. How frequently is your organization audited by an independent auditing firm? \_\_\_\_\_  
Attach a copy of your organization's last audit for the most recent fiscal year.

- L. Within the past five (5) years, have independent audits identified deficiencies which resulted in questioned costs, costs recommended for disallowance, an "adverse opinion" by the auditors, or the auditors "disclaiming" any opinions?

\_\_\_\_ Yes \_\_\_\_ No If yes, explain.

- M. Is your organization certified by the Washington State Office of Minority and Women's Business Enterprises as a minority and/or woman-owned enterprise?

\_\_\_\_ Yes \_\_\_\_ No If yes, provide certification number and date of certification or renewal.

- N. Is your organization currently receiving other funding to provide program services as described in Attachment B: Statement of Work or a similar program?

\_\_\_\_ Yes \_\_\_\_ No If yes, describe.

- P. Is your organization covered by fidelity/employee dishonesty bonding?

\_\_\_\_ Yes \_\_\_\_ No If yes, state amount, carrier, and coverage period.

- Q. Does your organization carry general liability insurance? Professional liability? Auto?

\_\_\_\_ Yes \_\_\_\_ No If yes, state amount, carrier, and coverage period.

- R. Does any employee or official of Clark County, or member of any County Advisory Board have any financial or other interest in your agency or this project?

\_\_\_\_ Yes \_\_\_\_ No If yes, explain.

- S. Does your organization guarantee that, in connection with this proposal, the prices and/or cost data have been arrived at independently, without consultation, communication, or agreement for the purpose of restricting competition?

\_\_\_\_ Yes \_\_\_\_ No If no, explain.

- T. Does your organization guarantee that fees for services quoted in response this RFP are not in excess of those which would be charged any other individual for the same services performed by your agency?

\_\_\_\_ Yes \_\_\_\_ No If no, explain.

I certify that this agency has never been debarred or suspended or otherwise excluded from or are ineligible for participation in Federal Assistance programs under Executive Order 12549, "Debarment and Suspension" and we will not contract with a subcontractor that is debarred or suspended. PACT funding, should it be awarded, will not be used to supplant any existing housing or mental health programming.

I, the undersigned have read and reviewed all of the above statements and attest, to the best of my knowledge, that they are correct and that I have the legal authority to commit this agency to a contractual agreement.

---

Signature, Chief Administrator of Applicant Agency

## **Request for Proposal # 485**

### **Program for Assertive Community Treatment**

#### **Part III. PROGRAM QUESTIONS/DESCRIPTION**

##### **A. Experience in Service Provision**

Please describe and document your agency's experience with:

1. Providing services to adult persons with mental illness who are transitioning from institutional care, including state and local hospitals, and jails.
2. Providing mental health services in Clark County.
3. Engaging difficult-to-serve persons, for whom standard case management services are not successful, with intensive outreach and engagement strategies.
4. Providing 24-hour, 7 days a week face-to-face crisis response.
5. Provision of multidisciplinary team services for individuals who experience mental illness.
6. Provision of evidenced-based practices, including those that require ongoing fidelity measurement such as PACT, Integrated Dual Diagnosis Disorder Treatment, Family Psycho Education and Supported Employment.
7. Provision of services that promote community tenure and/or reduce recidivism (include outcome data that demonstrates current program performance where available).
8. Interfacing with the criminal justice system, including police, the Department of Corrections, other jails and the courts.
9. Interacting with financial entitlement programs to access benefits for eligible persons.
10. Coordination with affordable housing providers, public housing authorities, and other housing resources to secure housing and providing housing support services. Describe success in accessing these services.
11. Development of housing resources, procuring subsidies and capital housing projects.
12. Providing culturally relevant services to diverse populations.
13. Involving program consumers and their families in the conceptualization, planning, implementation, and evaluation of mental health services, including in the writing of this proposal.

## **B. Services to Be Provided**

Demonstrate understanding of the PACT model and commitment to operating the PACT model with high fidelity by responding to each of the content areas below.

### **1. Staff Composition, Roles, Hours of Operation, and Training:**

- a. Describe how your agency will staff and structure the PACT Team to provide a 1:8 staff to consumer ratio and provide 24 hour 7 days a week face-to-face crisis response and intervention. Include the number of staff scheduled each day and how many hours they are scheduled.
- b. Describe how your agency will utilize a team approach to sharing caseload responsibility.
- c. Describe the activities and tasks staff will perform during non-traditional hours (Saturdays, Sundays, holidays).
- d. Describe the role and responsibility of the paid certified peer counselor(s) on the team.
- e. Describe the role and responsibility of the nurses on the team.
- f. Describe your agency's staffing plan, including disciplines, position titles, qualifications, number of positions, and full time equivalents, for this project.
- g. Describe your agency's program start-up, team building and staff training activities. Describe in detail the training needs of program staff, including specific staff competencies and practice guidelines needed to implement the PACT model. The RSN will work collaboratively with the PACT Team to identify and make available training resources.

### **2. Program Size, Location and Intensity:**

- a. Describe your agency's plan for service intensity or amount of face-to-face time with each participant per week.
- b. Describe your agency's plan for frequency of contact or number of face-to-face contacts for each participant per week.
- c. Describe your agency's plan to identify and serve individuals residing in locales outside the core area of the City of Vancouver.

3. Admission and Discharge Activities:

- a. Describe how your agency will identify, assess, and enroll individuals hospitalized at Western State Hospital or those at risk of being hospitalized or hospitalized at community psychiatric hospitals in the CCRSN region, at local jails and other persons who are high utilizers of the mental health system.
- b. Describe your agency's criteria for discharging and/or graduating participants from the PACT Team and how it will affect their recovery and housing.

4. Team Communication and Planning:

- a. Describe how your agency will structure team meetings and communication among team members regarding consumer status.
- b. Describe how your agency will conduct recovery treatment planning and who will be involved.

5. PACT Services:

- a. Describe how your agency will provide treatment to individuals with a co-occurring mental health and substance abuse disorder.
- b. Describe how protective payee services will be structured for participants.
- c. Describe how treatment issues related to older adults will be addressed.
- d. Describe how the recovery model will interface with the PACT model.
- e. Describe the range of treatment philosophies and intervention strategies that will be used by the Contractor in response to homeless persons with a mental illness or mental illness and co-occurring substance abuse.
- f. Describe your agency's plan to assist participants to make connections and to integrate into their new community and neighborhood.
- g. Describe your agency's plan to assist participants in strengthening existing and building new natural supports in their community.

- h. Describe how your agency will provide employment services, the employment model and practices that will be utilized, including at what point in the engagement/enrollment process employment is introduced to the participant.
- i. Describe how your agency will assist participants in learning the skills necessary to meet their obligations as tenants.
- j. Describe how your agency will provide dental and medical/health assessments and services.
- k. Describe your agency's plan to ensure transportation is available to PACT participants for scheduled and emergency appointments. Include your agency's capability to transport participants.
- l. Describe how your agency will assist participants with their medication management needs.
- m. Describe how your agency will provide accessibility of services for minority and non-English speaking persons.
- n. Describe your agency will provide gender, age, sexual orientation, ethnic and culturally relevant services and address related factors such as geographic and economic environments.
- o. Describe how your agency will assist and expedite eligible participants in obtaining income support services, including food stamps, Supplemental Security Income, Medicaid benefits and/or other entitlements.

### **C. Housing**

- 1. Describe your agency's existing housing resources and what if any will be specifically identified for PACT participants.
- 2. Describe your agency's plan to develop, acquire and/or partner with a housing provider or property owner for new long-term housing resources.
- 3. Describe your agency's plan to provide harm-reduction (abstinence encouraged) housing options.
- 4. Describe your agency's plan and budget amount to provide emergency and planned respite for program participants who need to leave their housing unit on short notice, either temporarily or permanently.

5. Describe the housing support services that will be provided to consumers to ensure they meet the obligations of tenancy and integrate successfully with their surrounding community.

#### **D. Evidence-based/Promising Practices**

This section should demonstrate your agency's understanding of evidenced-based/promising practices and the likelihood of them being successfully integrated. Practices that should be considered in this group should include but may go beyond SAMSHA's Evidence-based Practices of Integrated Dual Disorder Treatment, Supported Employment, Illness Management and Family Psycho-Education. Your agency should demonstrate a commitment to evidence-based practices and a willingness to implement evidence-based practice guidelines, train staff to the practices, and monitor fidelity to these standards.

Proposals should describe your agency's plan of each of the areas below:

1. Describe which evidence-based practices the agency believes are feasible in this PACT program at the existing funding level.
2. Describe how your agency will staff and structure their staff to meet the PACT requirements and the evidence-based practice standards.
3. Describe the training needs of program staff to implement each of the evidence-based practices the agency commits to develop within the PACT.
4. Describe how your agency will monitor fidelity to these practices.

#### **E. Collaboration**

This section should demonstrate your agency's understanding of and ability to achieve collaborative and working relationships necessary for the successful development of this program.

1. Describe your agency's plan for developing collaborative working relationships with local police jurisdictions, hospitals, community health clinics, jails, local DSHS CSO offices, homeless service providers, and Clark County DMHPs.
2. Describe your agency's plan to collaborate with mainstream and other employment programs/services.
3. Provide a description of the process that will be implemented for involving families and program participants in the conceptualization, planning, implementation and evaluation of the individual's recovery plan.

## **F. Budget Detail and Narrative**

Provide an annualized (12-month period) Line Item Budget attached as Part IV – Budget Summary.

1. Provide detailed information of the staffing configuration and the costs for proposed staffing.
2. Specify the source and amount of any funds and resources to be used from other sources.
3. Describe how the budget sufficiently supports the proposed response to the requirements of the RFP.
4. Describe how records will be maintained identifying the source and application of funds provided.
5. Please identify any start-up funds needed to implement the program.
6. Provide a program implementation schedule, including the start-up to full implementation. Describe your agency's ability to meet the start-up timelines specified in the RFP.
7. Specify the nature of any services that are to be subcontracted, including the service(s) and the subcontractor(s), if any.

## **G. Provider Performance of Current and Past Projects and Contracts**

This section should demonstrate your agency's performance in implementing similar projects as reflected in reports provided by proposers, site visit performance information, success in implementing new projects according to award specifications, demonstrated fiscal management, and demonstrated compliance with contract reporting requirements.

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**Part IV BUDGET SUMMARY** - Provide an annualized line item budget which details proposed expenditures in the following detail: (Please attach a spreadsheet labeled Part IV, Budget Summary)

1. Salaries and wages (identify individual position(s) salary)
2. Personnel benefits
3. Supplies
4. Professional services
5. Communication (telephone and postage)
6. Operating rentals and leases
7. Insurance
8. Public Utility Service
9. Miscellaneous
10. Indirect/Administrative Costs

The successful applicant is expected to identify expenses associated with this service separately within an accounting system including indirect costs. Please include as an attachment a summary of all other revenue sources which support the agency.

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**ATTACHMENT B**

**STATEMENT OF WORK**  
**Program for Assertive Community Treatment (PACT)**

**A. Goal**

To implement a high fidelity PACT project that provides intensive community supports including treatment, supportive services, and housing, and that will result in a reduction in the utilization of the state hospital, local psychiatric hospitals and emergency rooms, and local jails.

**B. Target Population**

The following criteria must be met for persons to be determined eligible to participate in PACT:

1. Persons must be at least 18 years of age;
2. Priorities will be given to persons residing at Western State Hospital, in an inpatient setting, at Hotel Hope, at a jail in Clark County, and who are clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available; or
3. Persons must have a severe and persistent mental illness as defined by the DSM IVR of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability (DSM IVR 295-296 Axis 1 Diagnosis). Consumers with other psychiatric illnesses that meet the Washington State Access to Care Standards are eligible.
4. Persons are high utilizers of acute services, and/or;
5. Persons are long-term users of the involuntary treatment system.

**C. Definitions**

D. Number of Program Consumers to be served

The Contractor must enroll 42-50 unduplicated consumers in the PACT program by April 1, 2008 and thereafter. It is expected that enrollment be staggered with 5-6 consumers enrolled each month for nine months beginning July 1, 2007.

E. Staffing

1. The Contractor will dedicate staff and incorporate treatment strategies to provide services to a broad spectrum of participants with a variety of clinical diagnoses, levels of functioning, and varying degrees of mental health and substance abuse/chemical dependency issues.
2. The Contractor will ensure that services are provided by staff that are professional, competent, effective, and have expertise in providing the PACT model, recovery-based services, and supported employment to participants with severe mental illnesses and substance abuse disorders. Staff will provide services in the participant's environment in the least intrusive and most culturally and age relevant manner possible.
3. The Contractor will ensure that the multidisciplinary PACT Team includes the following staff disciplines: psychiatric prescriber, nurse (RN), mental health professional, chemical dependency specialist, vocational specialist, and peer counselor. The Contractor will provide 16 hours per week of psychiatric prescriber time for every 50 consumers.
4. The Contractor will ensure that staff communication adheres to PACT guidelines for clinical supervision and staff meeting schedules including the daily organizational staff meetings.

F. Program Requirements

The Contractor will ensure that the following standards are met and that the PACT program will maintain a 90% compliance with the PACT fidelity scale (Attachment A).

1. Human Resources, Structure and Composition:
  - a. Small caseloads with a participant/provider ratio of 8:1 (not including the prescriber and program assistant).
  - b. A team approach, whereby the entire team shares responsibility for each participant;

- c. Regular team program meetings to plan and review services for each participant;
- d. A practicing Team Leader who provides direct service to participants in the program;
- e. Continuity of staffing is maintained over time;
- f. Program operates with full staff and minimal position vacancies;
- g. A psychiatrist or psychiatric nurse practitioner (ARNP) for the team;
- h. Nurses for the team (minimum of 1.5 FTE);
- i. Mental health professionals for the team;
- j. Vocational specialist for the team;
- k. Chemical dependency specialist for the team;
- l. Certified Peer counselors for the team (minimum of 1.0 FTE);
- m. Program is of sufficient size to consistently provide necessary staffing diversity and coverage.

2. Organizational Boundaries:

- a. Explicit eligibility and admission criteria that are clearly and operationally defined;
- b. The intake rate is sufficient to maintain a stable service environment;
- c. The program has full responsibility to provide all support and treatment services;
- d. The program has responsibility to provide 24-hour crisis intervention;
- e. The program has responsibility for referral and coordination of hospital admissions;
- f. The program has responsibility for coordination and planning of hospital discharges;

- g. There are no arbitrary time limits for participants to remain in the program.
- h. There are clear discharge criteria per Washington State PACT Standards, Draft 10/04/06 (Appendix II)

3. Nature of Services:

- a. The program will maintain a recovery-based individual service plan in accordance with approved procedures and operate with a recovery philosophy. The program should use Wellness Recovery and Action Plan (WRAP) services and also refer consumers to self-help programs and advocacy programs that support recovery.
- b. The program services are carried out primarily in the community instead of the office;
- c. The program actively engages and retains participants in a mutually satisfactory level;
- d. Assertive engagement techniques, such as street outreach are used to ensure ongoing engagement;
- e. Frequency of contact includes a high number of face-to-face service contacts as needed;
- f. The program provides support and skills for participant's informal/natural support network;
- g. The program utilizes an integrated treatment model for individuals with a co-occurring disorder.
- h. Certified Peer counselors are paid and integrated members of the team who provide direct service within the scope of their ability;
- i. The program will maintain a recovery-based individual service plan in accordance with approved procedures.

G. Housing

The Contractor will actively pursue housing subsidies, and/or capital development funds to develop long-term housing for the PACT participants that can be brought on line no later than the beginning of calendar year 2010.

1. The Contractor will coordinate and participate with Clark County on the 10 year plan to end homelessness.
2. The Contractor shall provide consumers a choice of long-term subsidized housing in the PACT service area. The housing options shall include primarily individual studio or one bedroom apartments and may also include cluster homes and single room occupancy units.
3. The Contractor shall work collaboratively with Clark County RSN, Public Housing Authorities, public funders, affordable housing providers, and private property owners to develop and/or secure long-term subsidized housing.
4. The Contractor shall provide access to their current housing resources for utilization in relation to the PACT.
5. The Contractor shall network with DSHS (e.g., Assisted Living, COPES program, Adult Home care) to secure housing and resources for consumers needing a higher level of care but who want to remain in independent living environments.
6. The Contractor shall make available harm-reduction (abstinence encouraged) housing options.

#### H. Collaboration

1. The Contractor shall establish collaborative working relationships with families and program participants and enlist their involvement in the ongoing planning and evaluation of PACT services.
2. The Contractor shall establish collaborative working relationships with law enforcement, community-based organizations involved in service delivery to the target population including faith communities, drop-in centers, meal programs, shelters, health clinics, and other similar organizations as well as the local emergency rooms, and Clark County Designated Mental Health Professionals (DMHPs). Memorandums of Understanding or Working Agreements will be developed and provided to the County by May 1, 2007.

3. The Contractor will ensure representation to and work collaboratively with the new PACT Advisory Group that will be established with members from the current COMET/YORP Oversight Committee and the addition of consumers.
4. The Contractor shall participate in the planning and collaboration of local continuum of care committees affecting PACT participants.
5. The Contractor shall develop and maintain productive working relationships with housing providers that provide housing for the PACT participants.
6. The Contractor shall establish collaborative working relationships with mainstream employment services, such as the Work Source Centers, the Division of Vocational Rehabilitation, and local colleges.

## I. Reporting Requirements

### 1. Data Collection

- a. The Contractor will collect and report participant data to the CCRSN Information System according to the CCRSN Information System Policies and Procedures and the contract.
- b. The Contractor will collect and report consumer data on the following outcome measures:
  - The number of consumers who become enrolled in PACT.
  - The number of enrolled consumers transitioned into permanent housing.
  - The number of enrolled consumers transitioned into employment.

### 2. Reports

- a. The Contractor will submit quarterly reports to CCRSN on progress required by the contract within 20 days of the end of a contract quarter. These reports will include:
  - The information required in section 1.b. above.
  - Barriers and challenges to program success.
- b. The Contractor will participate with CCRSN in measuring, reporting, and evaluating the project.

- c. Failure to submit required reports within the time specified may result in corrective action.

J. Record Keeping

The Contractor will maintain records that adequately identify the source and application of funds provided for financially assisted activities.

K. Timeline for Project Start-Up

Schedule of Activities

March 1, 2007	Contract signed between RSN and PACT Contractor
March 1 – April 30, 2007	Development of PACT infrastructure, including recruitment, hiring and team building activities
May 1 – June 30, 2007	PACT Teams are fully staffed and trained
July 1, 2007	Initiate identification, engagement, and enrollment of PACT program participants
April 1, 2008	42-50 consumers are fully enrolled

**Request for Proposal # 485**  
**Program for Assertive Community Treatment**

**ATTACHMENT C**

**Washington State PACT Program Standards**

*Draft 10/04/06*

**I. Introduction**

The Program for Assertive Community Treatment (PACT) is a client-centered recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

The important characteristics of PACT programs are:

- PACT serves clients with severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. Consequently, the client group is often over represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.
- PACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services clients need to achieve their goals. The team is directed by a team leader and a psychiatric prescriber and includes a sufficient number of staff from the core mental health disciplines, at least one peer specialist, and a program or administrative support staff who work in shifts to cover 24 hours per day, seven days a week and to provide intensive services (multiple contacts may be as frequent as two to three times per day, seven days per week, which are based on client need and a mutually agreed upon plan between the client and PACT staff). Many, if not all, staff share responsibility for addressing the needs of all clients requiring frequent contact.
- PACT services are individually tailored with each client and address the preferences and identified goals of each client. The approach with each client emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.
- The PACT team is mobile and delivers services in community locations to enable each client to find and live in their own residence and find and maintain work in community jobs rather than expecting the client to come to the program. Seventy-five percent or

more of the services are provided outside of the program offices in locations that are comfortable and convenient for clients.

- PACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many clients benefit from the availability of a longer-term treatment approach and continuity of care. This allows clients opportunity to recompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

## II. Definitions

*Program of Assertive Community Treatment (PACT)* is a self-contained mental health program made up of a multidisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services clients need to achieve their goals. PACT services are individually tailored with each client through relationship building, individualized assessment and planning, and active involvement with clients to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The PACT team is mobile and delivers services in community locations rather than expecting the client to come to the program. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for clients. The clients served have severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. There should be no more than 8-10 clients to one staff member.

*PACT Service Coordination (Case Management)* is a process of organization and coordination within the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services each client expects to receive per his or her written individualized treatment plan and that are respectful of the client's wishes. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

*PACT Service Coordinator (Case Manager)* is the team member who has primary responsibility for establishing and maintaining a therapeutic relationship with a client on a continuing basis, whether the client is in the hospital, in the community, or involved with other agencies. In addition, the service coordinator leads and coordinates the activities of the individual treatment team (ITT). He or she is the responsible team member to be knowledgeable about the client's life, circumstances, and goals and desires. The service coordinator develops and collaborates with the client to write the treatment plan, offers options and choices in the treatment plan, ensures that immediate changes are made as the client's needs change, and advocates for the client's wishes, rights, and preferences. The service coordinator

also works with other community resources, including consumer-run services, to coordinate activities and integrate other agency or service activities into the overall service plan with the client. The service coordinator provides individual supportive therapy and is the first ITT member available to the client in crisis and provides primary support and education to the family and/or support system and other significant people. The service coordinator shares these tasks with other members of the individual treatment team who are responsible to perform them when the service coordinator is not working.

*Client* is a person who has agreed to receive services and is receiving client-centered treatment, rehabilitation, and support services from the PACT team.

*Client-Centered Individualized Treatment Plan* is the culmination of a continuing process involving each client, his or her family, and the PACT team, which individualizes service activity and intensity to meet client-specific treatment, rehabilitation, and support needs. The written treatment plan documents the client's self-determined goals and the services necessary to help the client achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services.

*Clinical Supervision* is a systematic process to review each client's clinical status and to ensure that the individualized services and interventions that the team members provide (including the peer specialist) are planned with, purposeful for, effective, and satisfactory to the client. The team leader and the psychiatric prescriber have the responsibility to provide clinical supervision which occurs during daily organizational staff meetings, treatment planning meetings, and in individual meetings with team members. Clinical supervision also includes review of written documentation (e.g., assessments, treatment plans, progress notes, correspondence).

*Comprehensive Assessment* is the organized process of gathering and analyzing current and past information with each client and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; and 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery. The results of the information gathering and analysis are used to establish immediate and longer-term service needs with each client and to set goals and develop the first individualized treatment plan with each client.

*Daily Log* is a notebook or cardex which the PACT team maintains on a daily basis to provide: 1) a roster of clients served in the program; and 2) for each client, a brief documentation of any treatment or service contacts which have occurred during the day and a concise behavioral description of the client's clinical status and any additional needs.

*Daily Organizational Staff Meeting* is a daily staff meeting held at regularly scheduled times under the direction of the team leader (or designee) to: 1) briefly review the service contacts which occurred the previous day and the status of all program clients; 2) review the service

contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out the day's service activities; and 4) revise treatment plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks.

*Daily Staff Assignment Schedule* is a written, daily timetable summarizing all client treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule will be developed from a central file of all weekly client schedules.

*Individual Treatment Team (ITT)* is a group or combination of three to five PACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned to work with a client by the team leader and the psychiatric prescriber by the time of the first treatment planning meeting or thirty days after admission. The core members are the service coordinator (case manager), the psychiatric prescriber, and one clinical or rehabilitation staff person who backs up and shares case coordination tasks and substitutes for the service coordinator when he or she is not working. The individual treatment team has continuous responsibility to be knowledgeable about the client's life, circumstances, goals and desires; to collaborate with the client to develop and write the treatment plan; to offer options and choices in the treatment plan; to ensure that immediate changes are made as a client's needs change; and to advocate for the client's wishes, rights, and preferences. The ITT is responsible to provide much of the client's treatment, rehabilitation, and support services. Individual treatment team members are assigned to take separate service roles with the client as specified by the client and the ITT in the treatment plan.

*Individual Supportive Therapy Counseling and Psychotherapy* are verbal therapies that help people make changes in their feelings, thoughts, and behavior in order to move toward recovery, clarify goals, and address self stigma. Supportive therapy and psychotherapy also help clients understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve role functioning, and evaluate treatment and rehabilitative services. Current psychotherapy approaches include cognitive behavioral therapy, personal therapy, and psychoeducational therapy.

*Initial Assessment and Client-Centered Individualized Treatment Plan* is the initial evaluation of: 1) the client's mental and functional status; 2) the effectiveness of past treatment; and 3) the current treatment, and rehabilitation and support service needs. The results of the information gathering and analysis are used to establish the initial treatment plan to achieve individual goals and support recovery. Completed the day of admission, the client's initial assessment and treatment plan guides team services until the comprehensive assessment and treatment plan is completed.

*Medication Distribution* is the physical act of giving medication to clients in a PACT program by the prescribed route which is consistent with state law and the licenses of the professionals

privileged to prescribe and/or administer medication (e.g., psychiatric prescribers, registered nurses, and pharmacists).

*Medication Error* is any error in prescribing or administering a specific medication, including errors in writing or transcribing the prescription, in obtaining and administering the correct medication, in the correct dosage, in the correct form, and at the correct time.

*Medication Management* is a collaborative effort between the client and the psychiatric prescriber with the participation of the Individual Treatment Team (ITT) to carefully evaluate the client's previous experience with psychotropic medications and side-effects; to identify and discuss the benefits and risks of psychotropic and other medication; to choose a medication treatment; and to establish a method to prescribe and evaluate medication according to evidence-based practice standards. The goal of medication management is client self-medication management.

*Peer Counseling* is counseling and support provided by team members who have experience as recipients of mental health services for severe and persistent mental illness. Drawing on common experiences as well as using and sharing his/her own practical experiences and knowledge gained as a recipient, peer counseling is supportive counseling that validates clients' experiences and provides guidance and encouragement to clients to take responsibility and actively participate in their own recovery.

*Psychiatric and Social Functioning History Time Line* is a format or system which helps PACT staff to organize chronologically information about significant events in a client's life, experience with mental illness, and treatment history. This format allows staff to more systematically analyze and evaluate the information with the client, to formulate hypotheses for treatment with the client, and to determine appropriate treatment and rehabilitation approaches and interventions with the client.

*Psychotropic Medication* is any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or anxiolytic agents.

*Shift Manager* is the individual (assigned by the team leader) in charge of developing and implementing the daily staff assignment schedule; making all daily assignments; ensuring that all daily assignments are completed or rescheduled; and managing all emergencies or crises that arise during the course of the day, in consultation with the team leader and the psychiatric prescriber.

*Stakeholder Advisory Groups* support and guide individual PACT team implementation and operation. Each PACT team shall have a Stakeholder Advisory Group whose membership consists of 51 percent mental health consumers and family members. It shall also include community stakeholders that interact with persons with severe and persistent mental illness (e.g.,

homeless services, food-shelf agencies, faith-based entities, criminal justice system, the housing authority, landlords, employers, and community colleges). In addition, group membership shall represent the local cultural populations. The group's primary function is to promote quality PACT programs; monitor fidelity to the PACT Standards; guide and assist the administering agency's oversight of the PACT program; problem-solve and advocate to reduce barriers to PACT implementation; and monitor/review/mediate client and family grievances or complaints. The Stakeholder Advisory Group promotes and ensures clients' empowerment and recovery values in PACT programs.

*Treatment Plan Review* is a thorough, written summary describing the client's and the individual treatment team's evaluation of the client's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last treatment plan.

*Treatment Planning Meeting* is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these meetings is for the staff, as a team, to thoroughly prepare for their work with each client. The team meets together to present and integrate the information collected through assessment in order to learn as much as possible about the client's life, their experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each client and their goals and aspirations; to participate in the ongoing assessment and reformulation of issues/problems; to problem-solve treatment strategies and rehabilitation options; and to fully understand the treatment plan rationale in order to carry out the plan for each client.

*Weekly Client Contact Schedule* is a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) which fulfill the goals and objectives in a given client's treatment plan. The individual treatment team (ITT) shall maintain an up-to-date weekly client contact schedule for each client per the client-centered individualized treatment plan.

### III. Admission and Discharge Criteria

#### A. Admission Criteria

Individuals must meet the following admission criteria:

1. Severe and persistent mental illness listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric Association) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Clients with other psychiatric illnesses are eligible dependent on the level of the long-term

disability. (Individuals with a primary diagnosis of a substance use disorder or mental retardation are not the intended client group.)

2. Significant functional impairments as demonstrated by at least one of the following conditions:
  - a. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
  - b. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
  - c. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
3. Continuous high-service needs as demonstrated by at least one of the following:
  - a. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.
  - b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
  - c. Coexisting substance use disorder of significant duration (e.g., greater than six months).
  - d. High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
  - e. Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness, or at imminent risk of becoming homeless.
  - f. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
  - g. Difficulty effectively utilizing traditional office-based outpatient services.
4. Documentation of admission shall include:

- a. The reasons for admission as stated by both the client and the PACT team.
- b. The signature of the psychiatric prescriber.

B. Discharge Criteria

1. Discharges from the PACT team occur when clients and program staff mutually agree to the termination of services. This shall occur when clients:
  - a. Have successfully reached individually established goals for discharge and when the client and program staff mutually agree to the termination of services.
  - b. Move outside the geographic area of PACT's responsibility. In such cases, the PACT team shall arrange for transfer of mental health service responsibility to a PACT program or another provider wherever the client is moving. The PACT team shall maintain contact with the client until this service transfer is arranged.
  - c. Demonstrate an ability to function in all major role areas (i.e., work, social, self-care) without requiring ongoing assistance from the program for at least two years without significant relapse when services are withdrawn.
  - d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the client.
2. Documentation of discharge shall include:
  - a. The reasons for discharge as stated by both the client and the PACT team.
  - b. The client's biopsychosocial status at discharge.
  - c. A written final evaluation summary of the client's progress toward the goals set forth in the treatment plan.
  - c. A plan developed in conjunction with the client for follow-up treatment after discharge.
  - d. The signature of the client, the client's service coordinator, the team leader, and the psychiatric prescriber.

*Policy and Procedure Requirements:* The PACT team shall maintain written admission and discharge policies and procedures.

#### IV. Service Intensity and Capacity

##### A. Staff-to-Client Ratio

Each PACT team shall have the organizational capacity to provide a minimum staff-to-client ratio of at least one full-time equivalent (FTE) staff person for every 10 clients (not including the psychiatric prescriber and the program assistant) for an urban team. Rural teams shall have the organizational capacity to provide a minimum staff-to-client ratio of at least one full-time equivalent (FTE) staff person for every 8 clients (not including the psychiatric prescriber and the program assistant).

##### B. Staff Coverage

Each PACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week.

##### C. Frequency of Client Contact

1. The PACT team shall have the capacity to provide multiple contacts per week with clients experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on client need and a mutually agreed upon plan between clients and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all clients requiring frequent contact.
2. The PACT team shall have the capacity to rapidly increase service intensity to a client when his or her status requires it or a client requests it.
3. The PACT team shall provide a mean (i.e., average) of three contacts per week for all clients. Data regarding the frequency of client contacts shall be collected and reviewed as part of the program's Continuous Quality Improvement (CQI) plan.

##### D. Gradual Admission of Team Clients

Each new PACT team shall stagger client admissions (e.g., 4-6 clients per month) to gradually build up capacity to serve no more than 100-120 clients (with 10-12 staff) on

any given urban team and no more than 42-50 clients (with 6-8 staff) on any given rural team.

## V. Staff Requirements

### A. Qualifications

The PACT team shall have among its staff persons with sufficient individual competence and professional qualifications and experience to provide the services described in Section VIII, including service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that clients obtain the basic necessities of daily life; and education, support, and consultation to clients' families and other major supports. The staff should have sufficient representation of the local cultural population that the team serves.

### B. Team Size

1. The urban program shall employ a minimum of 10 to 12 FTE multidisciplinary clinical staff persons including the team leader, 1 FTE peer specialist, one to 1.5 FTE program assistants, and 16 hours of psychiatric prescriber time for every 50 clients on the team.
2. The rural program shall employ a minimum of 6 to 8 FTE multidisciplinary clinical staff persons, including one team leader, one FTE peer specialist, one FTE program assistant, and 16 hours of psychiatric prescriber time for every 50 clients on the team.

### C. Mental Health Professional

Of the 10 to 12 FTE multidisciplinary clinical staff positions on an urban team, there are a minimum of 8 FTE mental health professionals (including one FTE team leader). On a rural team of 6 to 8 FTE multidisciplinary clinical staff, there are a minimum of 4.5 FTE mental health professionals. Mental health professionals have: 1) professional degrees in one of the core mental health disciplines; 2) clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting; and 3) clinical work experience with persons with severe and persistent mental illness. They are licensed or certified per the regulations of the state where the team is located and operate under the code of ethics of their professions. Mental health professionals

include persons with master's or doctoral degrees in nursing, social work, rehabilitation counseling, or psychology; diploma, associate, and bachelor's nurses (i.e., registered nurse); and registered occupational therapists.

1. Required among the mental health professionals are: 1) on an urban team, 5 FTE or at least 4 FTE registered nurses and 2) on a rural team, 2 FTE or at least 1.5 FTE registered nurses (for either team, a team leader with a nursing degree cannot replace one of these FTE nurses).
2. Also required among the mental health professionals are: 1) on an urban team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader) with at least one designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling; and 2) on a rural team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader) with designated responsibility for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling.
3. One or more mental health professionals with training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist.

The chart below shows the required staff on urban and rural teams.

Position	Urban	Rural
Team leader	1 FTE	1 FTE
Psychiatric prescriber	16 Hours for 50 Clients	16 Hours for 50 Clients
Registered Nurse	5 FTE or at Least 3 FTE	2 FTE or at Least 1.5 FTE
Peer Specialist	1 FTE	1 FTE
Master's level	4 FTE	2 FTE
Other level	1-3 FTE	1.5 – 2.5 FTE
Program/Administrative Assistant	1-1.5 FTE	1 FTE

#### D. Required Staff

1. *Team Leader:* A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the PACT team. The team leader has at least a master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatric prescriber.
2. *Psychiatric Prescriber:* A psychiatric prescriber may include a psychiatrist or a psychiatric nurse practitioner/clinical specialist in psychiatric-mental health nursing (per WAC 246-840-300). The psychiatric prescriber works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 clients. The psychiatric prescriber provides clinical services to all PACT clients; works with the team leader to monitor each client's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.
3. *Registered Nurses:* On an urban team, five FTE registered nurses or at least 3 FTE registered nurses, and on a rural team, 2 FTE registered nurses or at least 1.5 FTE registered. A team leader with a nursing degree cannot replace one of the FTE nurses.
4. *Master's Level Mental Health Professionals:* On an urban team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader) with at least one designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling. On a rural team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader) with designated responsibility for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling.
5. *Substance Abuse Specialist:* One or more mental health professionals with training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist.
6. *Peer Specialist:* A minimum of one FTE peer specialist on either an urban team or a rural team. A person who is or has been a recipient of mental health services for severe and persistent mental illness holds this position. Because of their life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote client self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each client's point of view and

preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

7. *Remaining Clinical Staff:* The remaining clinical staff may be bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions. A bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science, and work experience with adults with severe and persistent mental illness. A paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-services needs. Those paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.
8. *Program/Administrative Assistant:* The program/administrative assistant (1-1.5 FTE in an urban setting or 1 FTE in a rural setting) who is responsible for organizing, coordinating, and monitoring all nonclinical operations of PACT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for client and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and clients.

*Policy and Procedure Requirements:* The PACT team shall: 1) maintain written personnel policies and procedures for hiring; 2) establish core staff competencies, orientation, and training; and 3) maintain personnel files for each team member containing the job application, copies of credentials or licenses, position description, annual performance appraisals, and individual orientation and training plan.

## VI. Program Organization and Communication

### A. Hours of Operation and Staff Coverage

#### 1. Urban Teams

- a. The PACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. This means:
  - i. Regularly operating and scheduling staff to work two eight-hour shifts with a minimum of 2 staff on the second shift providing services at least 12 hours per day weekdays.
  - ii. Regularly operating and scheduling staff to work one eight-hour shift with a minimum of 2 staff each weekend day and every holiday.

- iii. Regularly scheduling mental health professionals on-call duty to provide crisis services and deliver services the hours when staff are not working. PACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or by going out to see clients who need face-to-face contact.
- iv. Regularly arranging for and providing psychiatric backup all hours the psychiatric prescriber is not regularly scheduled to work. If availability of the PACT psychiatric prescriber during all hours is not feasible, alternative psychiatric backup should be arranged (e.g., mental health center psychiatric prescriber, emergency room psychiatric prescriber).

## 2. Rural Teams

- a. The PACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. When a rural team does not have sufficient staff numbers to operate two eight-hour shifts weekdays and one eight-hour shift weekend days and holidays, staff are regularly scheduled to provide the necessary services on a client-by-client basis (per the client-centered comprehensive assessment and individualized treatment plan) in the evenings and on weekends. This means:
  - i. Regularly scheduling staff to cover client contacts in the evenings and on weekends.
  - ii. Regularly scheduling mental health professionals on-call duty to provide crisis services and deliver services the hours when staff are not working. PACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or in person.
  - iii. When a rural team does not have sufficient staff numbers to operate an after-hours on-call system, the staff should provide crisis services during regular work hours. During all other hours, the team may arrange coverage through a reliable crisis-intervention service. The rural team communicates routinely with the crisis-intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis-intervention service to clients who may need assistance and to provide effective ways for helping them). The crisis-intervention service should be expected to go out and see clients who need face-to-face contact.
  - iv. Regularly arranging for and providing psychiatric backup all hours the psychiatric prescriber is not regularly scheduled to work. If availability of the PACT psychiatric prescriber during all hours is not feasible, alternative psychiatric prescriber backup should be arranged (e.g., mental health center psychiatric prescriber, emergency room psychiatric prescriber).

B. Place of Treatment

Each new urban team shall set a goal of providing 75 percent of service contacts in the community in nonoffice-based or nonfacility-based settings, while each new rural team shall set a goal of providing 85 percent of service contacts in the community in nonoffice-based or nonfacility-based settings. Data regarding the percentage of client contacts in the community will be collected and reviewed to verify that goals are being met as part of the program's Continuous Quality Improvement (CQI) plan.

C. Staff Communication and Planning

1. The PACT team shall conduct daily organizational staff meetings at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:
  - a. The PACT team shall maintain a written daily log, using either a notebook or a cardex. The daily log provides:
    - i. A roster of the clients served in the program, and
    - ii. For each client, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the client's status that day.
  - b. The daily organizational staff meeting shall commence with a review of the daily log to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all clients.
  - c. The PACT team, under the direction of the team leader, shall maintain a weekly client schedule for each client. The weekly client schedule is a written schedule of all treatment and service contacts that staff must carry out to fulfill the goals and objectives in the client's treatment plan. The team will maintain a central file of all weekly client schedules.
  - d. The PACT team, under the direction of the team leader, shall develop a daily staff assignment schedule from the central file of all weekly client schedules. The daily staff assignment schedule is a written timetable for all the client treatment and service contacts and all indirect client work (e.g., medical record review, meeting with collaterals, job development, treatment planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that day.

- e. The daily organizational staff meeting will include a review by the shift manager of all the work to be done that day as recorded on the daily staff assignment schedule. During the meeting, the shift manager will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day, and the shift manager will be responsible for assuring that all tasks are completed.
  - f. During the daily organizational staff meeting, the PACT team shall also revise treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans.
2. The PACT team shall conduct treatment planning meetings under the supervision of the team leader and the psychiatric prescriber. These treatment planning meetings shall:
- a. Convene at regularly scheduled times per a written schedule maintained by the team leader.
  - b. Occur and be scheduled when the majority of the team members can attend, including the psychiatric prescriber, team leader, and all members of the ITT.
  - c. Require individual staff members to present and systematically review and integrate client information into a holistic analysis and prioritize issues.
  - d. Occur with sufficient frequency and duration to make it possible for all staff to be familiar with each client and their goals and aspirations; to participate in the ongoing assessment and reformulation of issues/problems; to problem-solve treatment strategies and rehabilitation options; to participate with the client and the ITT in the development and the revision of the treatment plan; and to fully understand the treatment plan rationale in order to carry out the plan for each client every six months.

D. Staff Supervision

Each PACT team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader and psychiatric prescriber shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

1. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with clients in regularly scheduled or crisis meetings to assess their performance, give feedback, and model alternative treatment approaches;
2. Participation with team members in daily organizational staff meetings and regularly scheduled treatment planning meetings to review and assess staff performance and provide staff direction regarding individual cases;
3. Regular meetings with individual staff to review their work with clients, assess clinical performance, and give feedback;
4. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment plans, treatment plan reviews); and
5. Written documentation of all clinical supervision provided to PACT team staff.
6. *Policy and Procedure Requirements:* The PACT team shall maintain written program organization policies and procedures, including required hours of operation and coverage, staff communication and planning, emphasis on team approach, and staff supervision, as outlined in this section.

## VII. Client-Centered Assessment and Individualized Treatment Planning

### A. Initial Assessment

An initial assessment and treatment plan shall be done the day of the client's admission to PACT by the team leader or the psychiatric prescriber, with participation by designated team members.

### B. Comprehensive Assessment

Each part of the assessment area shall be completed by an PACT team member with skill and knowledge in the area being assessed. A team member with training and interest in the area does each part and becomes the specialist in that particular area with the client. The assessment is based upon all available information, including that from client interview/self-report, family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. A comprehensive assessment shall be initiated and completed within one month after a client's admission according to the following requirements:

1. In collaboration with the client, the ITT will complete a psychiatric and social functioning history time line.
2. In collaboration with the client, the comprehensive assessment shall include an evaluation in the following areas:
  - a. *Psychiatric History, Mental Status, and Diagnosis:* The psychiatric prescriber is responsible for completing the psychiatric history, mental status, and diagnosis assessment. (Using information derived from the evaluation, a psychiatric prescriber or a clinical or counseling psychologist shall make an accurate diagnosis listed in the American Psychiatric Association's DSM IV.) The psychiatric prescriber presents the assessment findings at the first treatment planning meeting.
  - b. *Physical Health:* A registered nurse is responsible for completing the physical health assessment. The registered nurse presents the assessment findings at the first treatment planning meeting.
  - c. *Use of Drugs and Alcohol:* A team member with experience and training in dual diagnosis substance abuse assessment and treatment is responsible for completing the use of drugs and alcohol assessment. The substance abuse specialist presents the assessment findings at the first treatment planning meeting.
  - d. *Education and Employment:* A team member with experience and training in vocational assessment and services is responsible for completing the education and employment assessment. The vocational specialist presents the assessment findings at the first treatment planning.
  - e. *Social Development and Functioning:* A team member who is interested and skillful in attainment and restoration of social/interpersonal skills and relationships and who is knowledgeable about human development is responsible for completing the social development and functioning assessment. The team member who does the assessment presents the assessment findings at the first treatment planning meeting.
  - f. *Activities of Daily Living (ADL):* Occupational therapists and nurses are responsible to complete the ADL assessment because team members in these professions have training to conduct ADL assessments. Other staff members with training to do the assessment and who have interest in and compassion for clients in this area may complete the ADL assessment. The

team member who does the assessment presents assessment findings at the first treatment planning meeting.

- g. *Family Structure and Relationships*: Members of the client's individual treatment team (ITT) are responsible to carry out the family structure and relationships assessment. The staff members working with the family present the assessment findings at the first treatment planning meeting.

3. While the assessment process shall involve the input of most, if not all, team members, the client's psychiatric prescriber, service coordinator (case manager), and ITT members will assume responsibility for preparing the written narrative of the results and formulation of the psychiatric and social functioning history time line and the comprehensive assessment, ensuring that a psychiatric and social functioning history time line and comprehensive assessment are completed within one month of the client's admission to the program.
4. The service coordinator and ITT members will be assigned by the team leader in collaboration with the psychiatric prescriber by the time of the first treatment planning meeting or thirty days after admission.

#### C. Individualized Treatment Planning

Treatment plans will be developed through the following treatment planning process:

1. The treatment plan shall be developed in collaboration with the client and the family or guardian, if any, when feasible and appropriate. The client's participation in the development of the treatment plan shall be documented. The PACT team shall evaluate together with each client their needs, strengths, and preferences and develop together with each client an individualized treatment plan. The treatment plan shall identify individual issues/problems; set specific long- and short-term goals for each issue/problem which are measurable; establish the specific approaches and interventions necessary for the client to meet his or her goals, improve his or her capacity to function as independently as possible in the community, achieve the maximum level of recovery possible (i.e., meaningful, satisfying, and productive life).
2. As described in Section VI, PACT team staff shall meet at regularly scheduled times for treatment planning meetings. At each treatment planning meeting the following staff should attend: the team leader, the psychiatric prescriber, the service coordinator (case manager), individual treatment team members, the

peer specialist and all other PACT team members involved in regular tasks with the client.

3. Individual treatment team members are responsible to ensure the client is actively involved in the development of treatment (recovery) and service goals. With the permission of the client, PACT team staff shall also involve pertinent agencies and members of the client's social network in the formulation of treatment plans.
4. Each client's treatment plan shall identify issues/problems, strengths/weaknesses, and specific measurable goals. The treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals (achieve recovery) and identify who will carry out the approaches and interventions.
5. The following key areas should be addressed in every client's treatment plan: psychiatric illness or symptom reduction; housing; ADL; daily structure and employment; and family and social relationships. The service coordinator (case manager) and the individual treatment team, together with the client, will be responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the client's course of treatment (e.g., significant change in client's condition or goals) or at least every six months. Additionally, the service coordinator shall prepare a summary (i.e., treatment plan review) which thoroughly describes in writing the client's and the ITT's evaluation of his or her progress/goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last treatment plan. The plan and review will be signed or acknowledged by the client, the service coordinator, individual treatment team members, the team leader, the psychiatric prescriber, and all PACT team members.

*Policy and Procedure Requirement:* The PACT team shall maintain written assessment and treatment planning policies and procedures incorporating the requirements outlined in this section.

## **VIII. Required Services**

Operating as a continuous treatment service, the PACT team shall have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit.

Services shall minimally include the following:

### **A. Service Coordination**

Each client will be assigned a service coordinator (case manager) who coordinates and monitors the activities of the client's individual treatment team and the greater PACT team. The primary responsibility of the service coordinator is to work with the client to write the treatment plan, to provide individual supportive counseling, to offer options and choices in the treatment plan, to ensure that immediate changes are made as the client's needs change, and to advocate for the client's wishes, rights, and preferences. The service coordinator is also the first staff person called on when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

B. Crisis Assessment and Intervention

Crisis assessment and intervention shall be provided 24 hours per day, seven days per week. These services will include telephone and face-to-face contact and will be provided in conjunction with the local mental health system's emergency services program as appropriate.

C. Symptom Assessment and Management

This shall include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's mental illness symptoms, accurate diagnosis, and the client's response to treatment
2. Psychoeducation regarding mental illness and the effects and side effects of prescribed medications, when appropriate
3. Symptom-management efforts directed to help each client identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects
4. Individual supportive therapy
5. Psychotherapy

6. Generous psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover

D. Medication Prescription, Administration, Monitoring and Documentation

1. The PACT team psychiatric prescriber shall:
  - a. Establish an individual clinical relationship with each client
  - b. Assess each client's mental illness symptoms and provide verbal and written information about mental illness
  - c. Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatric prescriber will follow
  - d. Provide education about medication, benefits and risks, and obtain informed consent
  - e. Assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor and document medication side effects
  - f. Provide psychotherapy
2. All PACT team members shall assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects.
3. The PACT team program shall establish medication policies and procedures which identify processes to:
  - a. Record physician orders
  - b. Order medication
  - c. Arrange for all client medications to be organized by the team and integrated into clients' weekly schedules and daily staff assignment schedules
  - d. Provide security for medications (e.g., long-term injectable, daily, and longer term supplies) and set aside a private designated area for set up of medications by the team's nursing staff
  - e. Administer medications per state law to team clients

E. Dual Diagnosis Substance Abuse Services

Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals. This shall include but is not limited to individual and group interventions in:

1. Engagement (e.g., empathy, reflective listening, avoid argumentation)
2. Assessment (e.g., stage of readiness to change, client-determined problem identification)
3. Motivational enhancement (e.g., developing discrepancies, psychoeducation)
4. Active treatment (e.g., cognitive skills training, community reinforcement)
5. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans)

Prochaska, J.O., DiClemente, C. C. The transtheoretical approach: Crossing traditional boundaries of therapy. Homewood, IL: Dow Jones/Irwin. 1984.

Monti, P., Abrams, D., Caden, R., & Cooney, N. Treating Alcohol Dependence. New York: Guilford. 1989.

Meyers, R. & Smith, J. Clinical Guide to Alcohol Treatment. New York: Guilford. 1995.

#### F. Work-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and involve job development and coordination with employers but also includes but not necessarily limited to:

1. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs
2. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations
3. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job

4. Individual supportive therapy to assist clients to identify and cope with the symptoms of mental illness that may interfere with their work performance
5. On-the-job or work-related crisis intervention
6. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation

#### G. Activities of Daily Living Services

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to:

1. Find housing which is safe, good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating; and procuring necessities (such as telephones, furnishings, linens)
2. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry
3. Carry out personal hygiene and grooming tasks, as needed
4. Develop or improve money-management skills
5. Use available transportation
6. Have and effectively use a personal physician and dentist

#### H. Social/Interpersonal Relationship and Leisure-Time Skill Training

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure clients' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

1. Improve communication skills, develop assertiveness, and increase self-esteem, as necessary
2. Develop social skills, increase social experiences, and where appropriate, develop meaningful personal relationships
3. Plan appropriate and productive use of leisure time
4. Relate to landlords, neighbors, and others effectively
5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

#### I. Peer Support and Wellness Recovery Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self-imposed stigma:

1. Illness Management and Recovery (IMR) services
2. Wellness Recovery and Action Plan (WRAP) services
3. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery
4. Other peer counseling and support

#### J. Support Services

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to:

1. Medical and dental services
2. Safe, clean, affordable housing
3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance)

4. Social service
5. Transportation
6. Legal advocacy and representation

**K. Education, Support, and Consultation to Clients' Families and Other Major Supports**

Services provided under this category to clients' families and other major supports with client agreement or consent, include:

1. Individualized psychoeducation about the client's illness and the role of the family in the therapeutic process
2. Individualized psychoeducation about the client's illness and the role of other significant people in the therapeutic process
3. Family intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
4. Ongoing communication and collaboration, face-to-face and by telephone, between the PACT team and the family
5. Introduction and referral to family self-help programs and advocacy organizations that promote recovery
6. Assistance to clients with their children, including individual supportive counseling, parenting training, and service coordination but not limited to:
  - a. Services to help clients throughout pregnancy and the birth of a child
  - b. Services to fulfill parenting responsibilities and coordinating services for the child
  - c. Services to restore relationships with children who are not in the client's custody

*Policy and Procedure Requirement:* The PACT team shall maintain written policies and procedures for all services outlined in this section.

**IX. Client Medical Record**

- A. The PACT team shall maintain a treatment record for each client.

- B. The treatment record is confidential, complete, accurate, and contains up-to-date information relevant to the client's care and treatment.
- C. The record shall accurately document assessments, treatment plans, and the nature and extent of services provided, such as a person unfamiliar with the PACT team can easily identify the client's treatment needs and services received.
- D. The team leader and the program assistant shall be responsible for the maintenance and security of the client treatment records.
- E. The client records are located at PACT team headquarters and, for confidentiality and security, are to be kept in a locked file.
- F. For purposes of confidentiality, disclosure of treatment records by the PACT team is subject to all the provisions of applicable state and federal laws.
- G. Clients shall be informed by staff of their right to review their record and the process involved to request to do so.
- H. Each client's clinical record shall be available for review and to be copied by the client and the guardian, if any.

*Policy and Procedure Requirement:* The PACT team shall maintain written medical records management policies and procedures.

#### **X. Client Rights and Grievance Procedures**

- A. PACT teams shall be knowledgeable about and familiar with client rights including the rights to:
  - 1. Confidentiality
  - 2. Informed consent to medication and treatment
  - 3. Treatment with respect and dignity
  - 4. Prompt, adequate, and appropriate treatment
  - 5. Treatment which is under the least restrictive conditions
  - 6. Nondiscrimination

7. Control of own money
  8. Grieve or complain
- B. PACT teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce client rights:
1. Grievance or complaint procedures under state law
  2. Medicaid
  3. Americans with Disabilities Act
  4. Protection and Advocacy for Mentally Ill Individuals
- C. PACT teams shall be prepared and provide clients appropriate information and referral to the Protection and Advocacy agency and other advocacy groups.

*Policy and Procedure Requirement:* The PACT team shall maintain client rights policies and procedures.

- XI.** Culturally and Linguistically Appropriate Services (CLAS) United States. Dept. of Health and Human Services. Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report. [Rockville, MD]: U.S. Dept. of Health and Human Services, 2001.
- A. PACT should ensure that clients receive from all staff members, effective understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
  - B. PACT teams should implement strategies to recruit, retain, and promote a diverse staff that are representative of the demographic characteristics of the service area.
  - C. PACT teams should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
  - D. PACT teams must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each client with limited English-proficiency at all points of contact, in a timely manner during all hours of operation.

- E. PACT teams must provide to clients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- F. PACT teams must assure the competence of language assistance provided to limited English-proficient clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except by request of the client).
- G. PACT teams must make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
- H. PACT teams should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- I. PACT teams should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, client satisfaction assessments and outcome-based evaluations.
- J. PACT should ensure that data on the individual client's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and be periodically updated.
- K. PACT teams should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and client involvement in designing and implementing CLAS-related activities.
- L. PACT should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by client.
- M. PACT is encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

*Policy and Procedure Requirement:* The PACT team shall maintain written Culturally and Linguistically Appropriate Services (CLAS) policies and procedures incorporating the requirements outlined in this section.

## **XII. Performance Improvement and Program Evaluation**

The PACT team shall have a performance improvement and program evaluation plan, which shall include the following:

- A. A statement of the program's objectives. The objectives shall relate directly to the program's clients or target population.
- B. Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.
- C. Methods for documenting achievements related to the program's stated objectives.
- D. Methods for assessing the effective use of staff and resources toward the attainment of the objectives.
- E. In addition to the performance improvement and program evaluation plan, the PACT team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.

*Policy and Procedure Requirement:* The PACT team shall maintain performance improvement and program evaluation policies and procedures.

### **XIII. Stakeholder Advisory Groups**

- A. The PACT team shall have a stakeholder advisory group to support and guide PACT team implementation and operation. The stakeholder advisory group shall have at least 51 percent mental health consumers and family members and include other community stakeholders such as representatives from services for the homeless, consumer-support organizations, food-shelf agencies, faith-based groups, criminal justice system, housing authorities, landlords, employers, and/or community colleges. Group membership should also represent the local cultural populations.

The stakeholder advisory group shall:

- 1. Promote quality PACT model programs
- 2. Monitor fidelity to the PACT program standards
- 3. Guide and assist with the administering agency's oversight of the PACT program

4. Problem-solve and advocate to reduce system barriers to PACT implementation
5. Monitor, review, and mediate client and family grievances or complaints
6. Promote and ensure clients' empowerment and recovery values in PACT programs.

*Policy and Procedure Requirement:* The PACT team shall maintain the written stakeholder advisory group policies and procedures, incorporating the requirements outlined in this section.

#### **XIV. Waiver of Provisions**

The PACT team may request of the PACT certification entity a waiver of any requirement of this standard that would not diminish the effectiveness of the PACT model, violate the purposes of the program, or adversely affect clients' health and welfare. Waivers cannot be granted which are inconsistent with client rights or federal, state, or local laws and regulations.

Attachment D

Assertive Community Treatment Fidelity Scale

Program \_\_\_\_\_ Respondent # \_\_\_\_\_ Role \_\_\_\_\_ Interviewer \_\_\_\_\_ Date \_\_\_\_\_

CRITERION		RATINGS / ANCHORS				
<b>HUMAN RESOURCES: STRUCTURE &amp; COMPOSITION</b>		(1)	(2)	(3)	(4)	(5)
H1	SMALL CASELOAD: Client/provider ratio of 10:1.	50 clients/clinician or more.	35 - 49	21 - 34	11 - 20	10 clients/clinician or fewer
H2	TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.	Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period.	10 - 36%.	37 - 63%.	64 - 89%.	90% or more clients have face-to-face contact with > 1 staff member in 2 weeks.
H3	PROGRAM MEETING: Program meets frequently to plan and review services for each client.	Program service- planning for each client usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least twice/week but less often than 4 times/week.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.
H4	PRACTICING TEAM LEADER: Supervisor of front line clinicians provides direct services.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup.	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25% and 50% time.	Supervisor provides services at least 50% time.

CRITERION		RATINGS / ANCHORS				
<b>HUMAN RESOURCES: STRUCTURE &amp; COMPOSITION</b>		(1)	(2)	(3)	(4)	(5)
H5	CONTINUITY OF STAFFING: Program maintains same staffing over time.	Greater than 80% turnover in 2 years.	60-80% turnover in 2 years.	40-59% turnover in 2 years.	20-39% turnover in 2 years.	Less than 20% turnover in 2 years.
H6	STAFF CAPACITY: Program operates at full staffing.	Program has operated at less than 50% of staffing in past 12 months.	50-64%	65-79%	80-94%	Program has operated at 95% or more of full staffing in past 12 months.
H7	PSYCHIATRIST ON STAFF: There is at least one full-time psychiatrist per 100 clients assigned to work with the program.	Program for 100 clients has less than .10 FTE regular psychiatrist.	.10-.39 FTE per 100 clients.	.40-.69 FTE per 100 clients.	.70-.99 FTE per 100 clients	At least one full-time psychiatrist is assigned directly to a 100-client program.
H8	NURSE ON STAFF: There are at least two full-time nurses assigned to work with a 100-client program.	Program for 100 clients has less than .20 FTE regular nurse.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two full-time nurses or more are members of a 100-client program.
H9	SUBSTANCE ABUSE SPECIALIST ON STAFF: A 100-client program includes at least two staff members with 1 year of training or clinical experience in	Program has less than .20 FTE S/A expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year S/A training or supervised S/A experience.

CRITERION		RATINGS / ANCHORS				
<b>HUMAN RESOURCES: STRUCTURE &amp; COMPOSITION</b>		(1)	(2)	(3)	(4)	(5)
	substance abuse treatment.					
H10	VOCATIONAL SPECIALIST ON STAFF: The program includes at least two staff members with 1 year training/experience in vocational rehabilitation and support.	Program has less than .20 FTE vocational expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year voc. rehab. training or supervised VR experience.
H11	PROGRAM SIZE: Program is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage.	Program has fewer than 2.5 FTE staff.	2.5 - 4.9 FTE	5.0 - 7.4 FTE	7.5 - 9.9	Program has at least 10 FTE staff.
<b>ORGANIZATIONAL BOUNDARIES</b>						
O1	EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally	Program has no set criteria and takes all types of cases as determined outside the program.	Program has a generally defined mission but the admission process is dominated by organizational convenience.	The program makes an effort to seek and select a defined set of clients but accepts most	Program typically actively seeks and screens referrals carefully but occasionally bows to organizational	The program actively recruits a defined population and all cases comply with explicit admission criteria.

CRITERION		RATINGS / ANCHORS				
HUMAN RESOURCES: STRUCTURE & COMPOSITION		(1)	(2)	(3)	(4)	(5)
	defined criteria to screen out inappropriate referrals.			referrals.	pressure.	
02	INTAKE RATE: Program takes clients in at a low rate to maintain a stable service environment.	Highest monthly intake rate in the last 6 months = greater than 15 clients/month.	13 -15	10 - 12	7 - 9	Highest monthly intake rate in the last 6 months no greater than 6 clients/month.

03	FULL RESPONSIBILITY FOR TREATMENT SERVICES: In addition to case management, program directly provides psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.	Program provides no more than case management services.	Program provides one of five additional services and refers externally for others.	Program provides two of five additional services and refers externally for others.	Program provides three or four of five additional services and refers externally for others.	Program provides all five of these services to clients
04	RESPONSIBILITY FOR CRISIS SERVICES: Program has 24-hour responsibility for covering psychiatric crises.	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for program clients.	Program is available by telephone, predominantly in consulting role.	Program provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement.	Program provides 24-hour coverage
05	RESPONSIBILITY FOR HOSPITAL ADMISSIONS: Program is involved in hospital admissions.	Program has involvement in fewer than 5% decisions to hospitalize.	ACT team is involved in 5% -34% of admissions.	ACT team is involved in 35% - 64% of admissions.	ACT team is involved in 65% - 94% of admissions.	ACT team is involved in 95% or more admissions.
06	RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: Program is involved in planning for hospital discharges.	Program has involvement in fewer than 5% of hospital discharges.	5% - 34% of program client discharges are planned jointly with the program.	35 - 64% of program client discharges are planned jointly with the program.	65 - 94% of program client discharges are planned jointly with the program.	95% or more discharges are planned jointly with the program.

07	TIME-UNLIMITED SERVICES (GRADUATION RATE): Program rarely closes cases but remains the point of contact for all clients as needed.	More than 90% of clients are expected to be discharged within 1 year.	From 38-90% of clients are expected to be discharged within 1 year.	From 18-37% of clients are expected to be discharged within 1 year.	From 5-17% of clients are expected to be discharged within 1 year.	All clients are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.
NATURE OF SERVICES						
S1	COMMUNITY-BASED SERVICES: Program works to monitor status, develop community living skills in the community rather than the office.	Less than 20% of face-to-face contacts in community.	20 - 39%.	40 - 59%.	60 - 79%.	80% of total face-to-face contacts in community

S2	NO DROPOUT POLICY: Program retains a high percentage of its clients	Less than 50% of the caseload is retained over a 12-month period.	50- 64%.	65 - 79%.	80 - 94%.	95% or more of caseload is retained over a 12-month period
S3	ASSERTIVE ENGAGEMENT MECHANISMS: As part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g., probation/parole, OP commitment) as indicated and as available.	Program passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms.	Program makes initial attempts to engage but generally focuses efforts on most motivated clients.	Program attempts outreach and uses legal mechanisms only as convenient.	Program usually has plan for engagement and uses most of the mechanisms that are available.	Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.
S4	INTENSITY OF SERVICE: High total amount of service time as needed.	Average of less than 15 min/week or less of face-to-face contact per client.	15 - 49 minutes / week.	50 - 84 minutes / week.	85 - 119 minutes / week.	Average of 2 hours/week or more of face-to-face contact per client.
S5	FREQUENCY OF CONTACT: High number of service contacts as needed	Average of less than 1 face-to-face contact / week or fewer per client.	1 - 2 / week.	2 - 3 / week.	3 - 4 / week.	Average of 4 or more face-to-face contacts / week per client.
S6	WORK WITH INFORMAL SUPPORT SYSTEM: With or without client present, program	Less than .5 contact per month per client with	.5-1 contact per month per client with support system	1-2 contact per month per client with support system in the	2-3 contacts per months per client with support system	Four or more contacts per month per client with

	provides support and skills for client's support network: family, landlords, employers.	support system.	in the community.	community.	in the community.	support system in the community.
S7	INDIVIDUALIZED SUBSTANCE ABUSE TREATMENT: One or more members of the program provide direct treatment and substance abuse treatment for clients with substance use disorders.	No direct, individualized substance abuse treatment is provided by the team.	The team variably addresses SA concerns with clients; no formal, individualized SA treatment provided.	While the team integrates some substance abuse treatment into regular client contact, they provide no formal, individualized SA treatment.	Some formal individualized SA treatment is offered; clients with substance use disorders spend less than 24 minutes/week in such treatment.	Clients with substance use disorders spend, on average, 24 minutes / week or more in formal substance abuse treatment.

S8	DUAL DISORDER TREATMENT GROUPS: Program uses group modalities as a treatment strategy for people with substance use disorders.	Fewer than 5% of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.	5 - 19%	20 - 34%	35 - 49%	50% or more of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.
S9	DUAL DISORDERS (DD) MODEL: Program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	Program fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Program uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for persuasion of clients in denial or who don't fit AA.	Program uses mixed model: e.g., DD principles in treatment plans; refers clients to persuasion groups; uses hospitalization for rehab.; refers to AA, NA.	Program uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalize for rehab. nor detox except for medical necessity; refers out some s/a treatment.	Program fully based in DD treatment principles, with treatment provided by program staff.
S10	ROLE OF CONSUMERS	Consumers have	Consumer(s) fill	Consumer(s) work	Consumer(s) work	Consumer(s)

	ON TREATMENT TEAM: Consumers are involved as members of the team providing direct services.	no involvement in service provision in relation to the program.	consumer-specific service roles with respect to program (e.g., self-help).	part-time in case-management roles with reduced responsibilities.	full-time in case management roles with reduced responsibilities.	are employed full-time as clinicians (e.g., case managers) with full professional status.
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Source: SAMHSA: <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/FidelityScale/default.asp>